

**RECORDS RELEASE AUTHORIZATION**

TO: \_\_\_\_\_  
Physician or Hospital

\_\_\_\_\_  
Address

I hereby request and authorize you to release to:

**Urology Associates of Elkhart, Inc.**

Jerald A. Hochstetler, M.D.  
Anish H. Nayee, M.D.  
Peter C. Fretz, M.D.  
Timothy J. Roth, M.D.

105 N. Nappanee Street  
Elkhart, IN 46514

- the complete history records in your possession concerning my medical care
- only medical records concerning my medical care and treatment for the time period of \_\_\_\_\_ to \_\_\_\_\_
- only medical records concerning my medical care and treatment for the diagnosis of \_\_\_\_\_

**Mental illness, substance abuse and/or HIV information**  SHOULD  SHOULD NOT be included.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**I understand this authorization may be revoked by written request.**

Date Requested: \_\_\_\_\_

Patient (or Guardian) Signature: \_\_\_\_\_

Urology Associates Account Number: \_\_\_\_\_

Witness: \_\_\_\_\_